AZ Medicaid Technical Consortium Meeting

October 12, 2006
1:30 PM to 2:30 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: ***Denny Bierl***

Attendees:
(Based on sign-in sheets)

Abrazo Health	**Capstone**	**MCP & Schaller**
*Jim Ten Eyck**	*Lydia Ruiz*	*Todd Cassel*
*JoAnn Ward**	**Care 1st**	*Maurice Hill*
ADHS	*Anna Castaneda*	*Cathy Jackson-Smith*
Kevin Gibson	*April Cotton Rapp*	*Walter Janzen*
Jerri Gray	*Gwen Morant*	**Pinal**
Paula Rendfield	**Centene**	*Cheryl Davis*
AHCCCS	*Rebecca Anderson**	*Jennifer Schwarz*
Peggy Brown	**Cochise Health Systems**	**UHC**
Deborah Burrell	*Marcia Goerdt**	*Susan Smith*
Christi Coppedge	**DES**	*Sean Steppe**
Leroy Geske	*David Gardner*	**UPC**
Karen Edgley	**HealthChoice**	*Julie Conrad**
Mary Kay McDaniel	*Jessica Lennick*	**United Drugs**
Jacqueline McElroy	*Janel Sturn*	*Alfonso Munguia*
Kermit Rose	*Charlotte Peoples*	*Matthew Brady*
APIPA		**Yavapai**
Lucy Markov		*Becky Ducharme**

teleconference

Welcome (Denny Bierl)

Denny introduced today's meeting by announcing there are several significant updates on readiness for NPI implementation. He then turned the meeting over to Mary Kay McDaniel to discuss NPI standards body activities.

NPI Activity and Standards Body Overview (Mary Kay McDaniel)

May Kay stated that output from X12, NCPDP, and HL7 have produced numerous changes, including a panel for the Health Information Technology Standards (HITSP). Information from the HITSP panel will filter down to X12, HL7, and NCPDP by setting the inoperability standards and doing the USE cases. The impact of this news from Congress is going to change the way the HIPAA law reads. The language in draft basically states that the standard setting body will drive which version is being used and the versions will turn around much faster than they have in the past. The expectation is that this mode of operation will put result in an 18-24 month track for each one of the standards, implying that a new 834 or 837 will occur every 24 months. The HIPAA mandated transaction will be de-linked and replace the way transactions were processed in a single set (i.e., the 230, 231, 236, 237, 835, 837). This means one version of an 837 could be run concurrently with a different version of an 835.

The first trip to HL7 in Boca Raton produced significant work on the claims attachment. The comments are done. CMS is reviewing the results to publish for the final outcome and is hoping for completion the first quarter of next year. The "reconciliation" conference is occurring as we speak on the HB 4157 and SB 1418 regarding Version 5010.

The XML piece of the clinical data architecture has some exciting attachments. From a health plan perspective, we should see a return on investment in that transaction over and above the process we are working with now. There are some words of caution: If you have a provider who can create a compliant COB transaction (i.e., a provider who can send you an 837 with all of the information that differentiates their previous payment from other payers), that provider cannot be required to send you a paper claim with the remit. If providers are sending remits electronically, the question of authenticity will be raised and you may not want to accept it. The rule states, however, that if a provider wants to submit a remit in another format than you normally accept, you will need to accept it electronically. The back part of the Federal Register covers COV transactions. For those who are refusing to accept these transactions, it will behoove you to review the policy.

NCPPD is actively working on the e-prescribing standard and the pharmacy attachment. It is hoped this will be accomplished and balloted for the January HL7. X12 was busy. The 820 got through. There are some issues with the banking piece and efforts were focused on achieving easier transaction acceptance within the banking industry. There are still same issues with the 835. PMC Bank was very vocal about how they are getting 835s and were promised a newer version which will be the 5010.

The next X12 meeting will examine the 5050 version. There is a sleeper issue out there that could seriously affect hospital transactions and some of the systems are beginning to realize it. The Medicare change request 5243 came out with on the taxonomy codes and is requiring the codes on institutional claims. This is forcing the industry down a path that may not be same path that all are taking. The result is the contractors shall instruct providers to report the service facility locator loop when the service is furnished at an address other than at the address reported on the claim for their billing or pay-to-provider. A secondary issue is that providers will be required to separate their batches of claims for each part that is identified by a different taxonomy code. This could double the size of the files.

Medicare will impose a standardized list of the taxonomy codes. Providers who have more than one current Medicare number will have to submit each institutional claim separately, in a batch, with a separate taxonomy code. If a taxonomy code for a particular facility is not the same taxonomy code that Medicare is requiring, a conflict will arise. There are two systems out there that can handle multiple taxonomy codes by provider. The providers are really having some issues with this situation.

For anyone who has not done the analysis for what the 835 was like on the back end, be prepared. The 835 cannot be broken by tax ID as financial people would like to believe. It breaks out at the header for

NPI. For AHCCCS, this is a challenge since AHCCCS does not use the tax ID or the NPI to sort the outgoing 835s but does use a payee ID which ultimately gets the tax ID. Again, this occurrence will produce a challenge.

AHCCCS Project Update General Items (Denny Bierl)

Denny presented an update on AHCCCS activities. Things have been busy. On the third weekend in September, NPI was promoted to production with the required changes to Claims and Encounters, Finance, Reinsurance, Web application and all related EDI transactions. There were six problem tickets post-production, two of which are still open but are minor. Things are well underway in terms of AHCCCS being ready on both the Encounter and on the Fee-For-Service Claims site. The changes to the MEVS system, which is the Emdeon white card system, will be promoted the third weekend of October. This will be accomplished to make sure that Emdeon can be handled by NPI and reported accordingly. This will be the last production promote.

There will be more testing of the entire system from back to front end with some of the more unique scenarios related to the NPI. Mary Kay addressed one of these scenarios that concerns us all – the 835 in terms of the sort, in terms of the report, and in terms of the different combinations that can exist between a group biller number and a service ID. There is a question of what to do with a group that has both atypical and typical providers.

While waiting for the plans and program contractors' testing, efforts are being made to circle back, assign four to five people to take a lead, and exercise the system a little more robustly. There is still some question about the readiness to handle every scenario and every combination that could evolve once the NPIs start coming in. No production files, including NPI, will be accepted until after the first of January.

October 15 is the beginning of the testing window with an eye toward finishing by February 28, 2007. Mandatory compliance is eight months away. The Agency is nearly ready from a systems perspective.

PAT File Changes (Larry Walker)

Larry described the major changes to the PAT process and stated that the transmission files won't be implemented until January. A letter was sent by Acute Care Operations the end of September to give notice of the changes.

One highlight of the changes in detailed record layout is that the 10-digit NPI will simply be added to the very end of the PR record layout. Testing will commence the beginning of November. Another highlight of change is that Operations has already collected the primary and alternate contact emails.

Whenever the PAT file has been processed on the agency end, an email will automatically be sent to give notice of the results of the file (passed, failed) and the error percentage rate. In connection with that email, the process will list the file names again. All the reports will now actually be downloaded to the AHCCCS outside server. The email that notices the file names will also be able to access them. An email was distributed the end of September with instructions for a macro. When it is saved to the hard drive, a link will be created to the desktop.

The forthcoming PAT User Manual will list the file names again. When the macro is opened, it will ask the file name that is listed in the Manual. The email will also provide the file names. The macro will take the mainframe AHCCCS report, which was generated, and save it to the hard drive. When that file is opened with the macro, it will automatically be reformatted into a Word document that can then be resaved. The document can be opened and searched for errors. A detailed transaction will be available along with the summary, totals, and error reports. Instead of a week or ten-day waiting period to get the report printed off at AHCCCS and mailed, there will be a 24-hour turnaround time right through the FTP server.

If there are any questions during the first-time walk-through, the help desk will be on hand with people who will have been trained in using this process. This 24-hour turn-around time will be a major improvement for everyone.

When an NPI is submitted, it will be compared to what the provider has actually presented to provider registration. If by any chance anything does not agree, or if the provider has submitted an NPI that is not in the PAT file before the official implementation date of May 23, 2007, the incident will be reported on an error report but it will not count against the error percentage rate of 3%. After May 23, however, if the NPI that the provider has given to provider registration is not in agreement with what is on record, then an error will be counted against the error percentage rate.

The PAT file changes will affect only the acute care plan.

Denny interjected that, out of the 40,000 NPIs that are expected, the grand total of the number actually received is just over 2,700. If the majority of codes, an influx of 30,000 or more, arrive in February and March, they will be a major challenge for Valerie and her staff.

Provider NPI Registration
Comments from Valerie Noor

Valerie announced that there was concern on the fee-for-service side about the low volume of incoming phone calls. The current response count doesn't begin to meet the anticipated readiness of the registration team to input the NPI numbers. Forthcoming information from providers about their requirements and signing off with an authorized signer should be submitted without delay so it can be loaded into the system.

An interesting scenario arose this past week. It was discovered that some providers had duplicate ID numbers. Those duplicate numbers will be pulled effective January 1, 2007.

In response to a member question about the availability of funding to share NPI data, Valerie commented that no dollars were allotted to CMS to provide a shared system across the industry. This reality has spurred other states to take action. In some cases, they have initiated consortiums of peers to pool files for sharing among themselves.

CMS will not be sharing their crosswalk for Medicare, at this time, nor will CMS be extending themselves to share their NPIs. This stand has many in an uproar. Rumor has it that CMS is allowing some access to the NPPS database by requiring a data use agreement but that has not necessarily been confirmed.

The lack of oversight sharing exists, in part, because data sharing is a rule-making process. Therefore, even if this issue is presented through the federal Office of Management and Budget (OMB), the decision to withhold an NPI data dissemination policy will be in effect. This matter is headed for the Federal Register. The publication process requires a gag period and a time for submitting comments. Every comment is addressed in an open forum. The estimated time frame looks like May 23, 2007 before the rule could actually exist in the Register. Thus, there is strong encouragement for the local consortiums to share their numbers.

Despite the restriction of access to CMS, there are resources available. There is a white paper on data sharing for the NPI which gives some standard formats for courses of action. There is also the NCPDP which has a database that is capturing NPIs as they are developed. Subscribers can expect to pay up to $8500 for this access. The NCPDP is reputed to be second to the NPPES in size to have the largest collection of NPIs at this time. Another organization, the Council for Affordable Quality Health Care (CAQH), is also gathering NPIs. These are a few of the information sharing mediums becoming available. It is doubtful that CMS will take on this responsibility any time soon because of the lack of funding for this objective. However, negotiations to obtain data have and can be made under certain conditions.

Despite all the difficulties, it behooves us to ensure that AHCCCS receives the NPIs. If AHCCCS determines that a provider needs an NPI and that that NPI is not in the AHCCCS database, the encounter will pend. Although health plans reportedly do not like to act in common to do things for providers, somebody needs to initiate some type of cooperative action.

It could be cost effective across the State if the health plans pooled resources to do one-day seminars, i.e. NPI boot camps. This is happening in some of the other states. Oregon, for instance, has done just that and their numbers are relatively successful. One of the things they did for their providers in those boot camps was to have people assist with completing the form. Computers were actually set up on site for the providers to enter the information electronically during the seminars. This seems to be an interesting way to accomplish the NPI effort with the providers.

Provider NPI Registration
Comments from Denny Bierl

Denny posed the following questions: Has anyone seen an NPI from a hospital system yet? Has anybody received more than 10% of the NPIs that were expected? An increase in provider response is imperative or the encounters will start to pend, and the claims will deny. We want to avert the impact of a sudden and last minute influx of NPIs for Valerie's team to load all at once.

There will soon be individual meetings with representatives of AHCCCS to discuss current status and future plans and activities related to NPI. These meetings are meant to be cooperative and constructive and partnership-based. However, the expectation of the representatives will be to see work plans that show reasonable task completion and due dates. For some groups, much work lies ahead to have a system is in place by the May 2007 due date. If the analysis phase is not complete and the required measure of effort not drawn by the time of those meetings, participants will be pressured for results.

Some specifics regarding testing have been included in the requirements. Lori Petri and Christi Coppedge will handle the contacts for this phase. Denny directed the groups to drop a note to the HIPAA Workgroup Consortium address when they are ready. Basic outlines have been provided regarding the expectations in terms of testing encounters submissions. The list is not all inclusive but outlines the minimums that need to be pushed through the system to ensure readiness for the May deadline. A submission of at least is 25 encounters in each batch is a reasonable goal. Not every possible scenario can be tested. The list is only a guide and requires some professional judgment.

Provider NPI Registration
Comments from Mary Kay McDaniel

Mary Kay offered the following recommendations:

1) "If you are testing in test, please test but do not use the test region to validate files." To do so can interfere with other processes especially when large encounter files are involved.

2) "I hope you have done analysis of the new paper forms and your systems have been modified." As of 10/01/06, the new forms were released. Providers are flocking to the new forms or will, at some point, when the current stock runs out.

AHCCCS is putting in a front-end validation system. This software is highly flexible and will allow any type of run. It is a web-based portal which means you can drive what you test, when you test, and how you test, and the responses will be out there for you to see. Claims adjustment reason codes are the codes that are out on the Washington Publishing Company (WPC) website (www.wpc-edi.com) and will not reject with the Validator.

AHCCCS does not use a taxonomy code to process a claim or an encounter, but if a group sends it, it will be required to be valid. Dora and Susan and Melanie are working to look at the community manager piece of this product that will be out there for you.

Something being reviewed in testing with the NPI and perhaps for regression testing is a better way to evaluate. This means it will be possible to determine just what was tested when somebody says "I tested." For example, if 1000 claims come in and they are all for the same provider or the same member with just different dates, we will be able to decipher if the same file was submitted four times and run successfully 4 times just by changing the control numbers, without having to review each encounter or each claim. We will be able to tell what scenarios went through. You all will be able to see

what is out there. We will not know whose files are being sent through as long as the wrappers have your name on them.

REDI will be in Arizona for a conference about the NPI during the week of November 6. Some sister agencies will be attending. There will be a pre-conference on the NPI, with more sessions on this subject throughout the rest of the week.

Medicare cross-over claims are a challenge and have required a juggling of numbers and coding in order to pull in the health plans. Suggestions will be offered about how to map those areas more smoothly.

Open Forum(Denny Bierl)

Denny stated that one of the fundamental decisions made in AHCCCS a long time ago was to have a one-to-one relationship between an NPI and an AHCCCS provider registration number to ensure that, when an NPI is submitted, it finds only one match within our system.

One question was submitted:

> Will we be able to receive encounters showing both an NPI and an AHCCCS ID during the period January 1 through May 23, 2007?
>
> Yes, you can submit both but with one caveat. When an NPI comes in, the second number will essentially be ignored so that the NPI number drives the transaction. If both numbers are sent, we are going to take the NPI and use it to process the encounter. If that NPI is not on file, the encounter will pend even though you sent correct the AHCCCS registration number. So, you can send both numbers but *be sure* the NPI is on file in the AHCCCS system before you do so.

A transaction will be processed as if it were the NPI that was received and that is what you will get back on the transaction.

It currently takes 48 hours to load NPI in the AHCCCS registration system – this will become more efficient as the volume increases and the numbers come in bunches.

AHCCCS will start sending the NPIs as they come in on the transmissions sent on the 1st and 15th of the month. They will be located at end of the existing layout record rather than in the middle, between the name and provider ID.

Future Meeting Frequency (Denny Bierl)

It was motioned that subsequent meetings should be held during the first week in December after the 7th, followed by January, February, and March, bypassing November.

The meeting was then adjourned.